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Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

I. Policy - Directed Plan of Correction

This policy is to implement the regulatory requirements at 42 CFR 488.424 for imposing a "directed plan of correction." A directed plan of correction is one of the Category 1 remedies the Bureau of Adult and Child Care (BACC) or the Health Care Financing Administration (HCFA) Regional Office can select when it finds a facility out of compliance with federal requirements.

Purpose

A directed plan of correction is a specific plan which BACC or the HCFA Regional Office develops that requires a facility to take action within specified time frames. The purpose of the directed plan of correction is to achieve correction and continued compliance with federal requirements.

Process

1. The directed plan of correction can be developed by BACC, the HCFA Regional Office, or the temporary manager - not the facility.

2. A directed plan of correction may be imposed 15 days after the facility receives notice for non-immediate jeopardy situations and two days after the facility receives notice for immediate jeopardy situations. The date the directed plan of correction is imposed does not mean that all corrections must be completed by that date.

3. Use of a directed plan of correction should be dependent upon causes identified by BACC, the HCFA Regional Office, SRS, or a temporary manager (with BACC, HCFA Regional Office, or SRS approval).

4. The elements of a directed plan of correction are:

   - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice;
   - How the facility will identify other residents having the potential to be affected by the same deficient practice;
   - What measures will be put into place for systemic changes made to ensure the deficient practice will not recur;

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- How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur (i.e., what program will be put into place to monitor the continued effectiveness of the systemic change);
- When corrective actions must be accomplished; and
- How substantial compliance will be measured.

5. Achieving compliance is the provider's responsibility. If the facility fails to achieve substantial compliance after complying with the directed plan of correction, BACC, the HCFA Regional Office, or SRS may impose another remedy until the facility achieves substantial compliance or is terminated from the Medicare or Medicaid program.

II. Policy - Directed Inservice Training

This policy is to implement the regulatory requirements at 42 CFR 488.425 for imposing "directed inservice training." Directed inservice training is one of the Category I remedies the Bureau of Adult and Child Care (BACC) or the Health Care Financing Administration (HCFA) Regional Office can select when they find a facility out of compliance with federal requirements.

Purpose

The purpose of directed inservice training is to provide basic knowledge to achieve compliance and remain in compliance with federal requirements.

Process

1. BACC's administrative staff, the HCFA Regional Office, or the State Department of Social and Rehabilitation Services (SRS) will determine when this type of remedy will be imposed.

2. Directed inservice training may be imposed 15 days after the facility receives notice of situations where there is no immediate jeopardy and 2 days after the facility receives notice for immediate jeopardy situations.

3. The facility will be notified in writing (along with other requirements or remedies as determined) by the administrative staff of BACC or HCFA Regional Office about what topics and type(s) of directed inservice training the facility must provide to its staff. It is the facility's responsibility to ensure that the appropriate staff attend the outlined inservice training program.

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4. Educational sources that need to be utilized when a directed inservice training program is required include, but is not limited to:

   - Programs developed by well established centers for geriatric health services education;
   - Schools of nursing or medicine;
   - Centers for aging;
   - Health education centers that have established programs in geriatrics and geriatric psychiatry; and/or
   - The ombudsman program.
   - Qualified consultants.

5. The facility will bear the expense of the directed inservice training.

6. Achieving compliance is the provider's responsibility. If the facility fails to achieve substantial compliance after complying with a directed inservice training, BACC, the HCFA Regional Office, or SRS may impose another remedy until the facility achieves substantial compliance or is terminated from the Medicare or Medicaid program.

7. After the training has been completed, BACC Field Services staff will assess whether compliance has been achieved. If the facility still has not achieved substantial compliance, the state Medicaid agency or the HCFA Regional Office may impose one or more additional remedies as specified in 42 CFR 488.406.

III. Policy - State Monitoring

This policy is to implement the regulatory requirements at 42 CFR 488.422 for imposing "state monitoring." State monitoring is one of the Category I remedies the Bureau of Adult and Child Care (BACC) or the Health Care Financing Administration (HCFA) Regional Office can select when they find a facility out of compliance with federal requirements.

Purpose

The purpose of a state monitor or state monitoring is to oversee the correction of cited deficiencies in the facility as a safeguard against further harm to the residents when harm or a situation with a potential for harm has occurred.

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Process

1. Monitors are identified by BACC as appropriate professionals who will be responsible for monitoring cited deficiencies in a manner determined by BACC.

   State monitoring is a process developed by BACC as an appropriate method or means by which cited deficiencies will be monitored.

2. A state monitor is an employee or a contract employee of BACC. (A contract employee may be retained by BACC if the necessary federal funds have been allocated to hire a contract employee.) The monitor will not be an employee or contractor of the monitored facility nor will this individual have an immediate family member as a resident in the monitored facility.

3. State monitoring will not be imposed on a facility when that facility has been found on three consecutive standard surveys to have provided substandard quality of care and/or as a selected Category I remedy for deficiencies rate "D" or "E" on the scope and severity scale. Otherwise, state monitoring may be considered an optional remedy. Some situations in which state monitoring may be appropriate include, but are not limited to, the following:

   - Poor facility history (i.e., a pattern of poor quality of care, many complaints);
   - BACC has concerns that the situation in the facility has the potential to worsen;
   - Immediate jeopardy exists and no temporary manager can be appointed;
   - If the facility refuses to relinquish control to a temporary manager, a monitor may be imposed to oversee termination procedures and transfers of residents; or
   - The facility seems unable or unwilling to take corrective action for cited substandard quality of care.

4. State monitors will have complete access to all areas of a facility.

5. Factors that will be used to decide how often a facility is monitored may include:

   - The nature and seriousness of the deficiency(ies) as specified by BACC; and/or
   - The timing and frequency of when the problems occurred (i.e., mealtimes, evening shifts, daily, etc.)

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6. When state monitoring is imposed as a remedy, BACC may select one or more of the following methods of state monitoring:

   - Assignment of a revisit or revisits;
   - A state monitor to do onsite visits on a routine regular basis (weekly, monthly, or quarterly);
   - A state monitor to perform random visits to the facility;
   - Any other methods of state monitoring developed by BACC.

7. The remedy will be discontinued when a facility has:

   - Its provider agreement discontinued; and/or
   - Demonstrated to the satisfaction of HCFA or BACC that the facility is in substantial compliance with requirements (if imposed for repeated substandard quality of care) that the facility will remain in substantial compliance.

IV. Policy - Conflict Prevention

In order to develop, implement, and cultivate a survey process for all types of providers which minimizes conflict between provider and survey agency, and to provide an opportunity for resolution of disagreements in a non-adversarial manner, the following procedure is adopted:

Process

1. Each surveyor is responsible to conduct the survey in a professional and amicable manner, including the establishment of a dialogue concerning findings identified by the survey process. The facility is responsible for the same professional and amicable conduct.

2. At the entrance conference, the survey team leader will provide the administrator with the list of materials needed to conduct the survey and a copy of this policy. The facility will provide information concerning where required items can be found.

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3. The surveyor is responsible to conduct a daily meeting with the administrator (or designated staff) to discuss the process of the survey, items not found, and areas where additional information may be needed. Facility staff should be prepared to present documentation from professional journals and references to support standard of care decisions. Examples of documentation would be a new pressure ulcer treatment regime or a method to deal with the behavior of a resident. The surveyor shall consider these sources before making final deficiency decisions. The regional manager may be contacted by the surveyor to discuss issues which need resolution during the survey.

4. The facility may present additional information during the scheduled exit conference. The surveyor shall consider this information in determining whether to retain a deficiency in question. The exit conference shall not be unduly delayed for this process. The facility shall have the opportunity to provide additional information through the plan of correction process. Pursuant to federal survey policy, surveyors are required to cite deficiencies even if the facility corrects the problem during the survey. The surveyor may note on the Statement of Deficiencies that the facility has initiated corrective action.

5. Upon termination of the exit conference, the surveyor will ask the facility to complete the comment form. The facility can indicate on the comment form issues of survey procedure or deficiency that may need resolution.

6. Upon receipt of the survey report, the regional manager will mail the questionnaire to the administrator asking for comments on the survey process. This questionnaire will be returned to the Topeka Office for review.

7. If the administrator does not believe their concerns about a deficiency or a procedure have been appropriately addressed, the regional manager may be contacted.

8. Informal conflict prevention (informal dispute resolution) is also required by 42 CFR 488.331. Requests for conflict prevention must be submitted in writing which includes an explanation of the specific deficiencies that are being disputed. The request must be made within 10 calendar days from the exit conference. If the same deficiency has been disputed on survey it cannot be disputed again on revisit. This request should be submitted to the Regional Manager. The regional manager will review the deficiency or deficiencies and may contact the surveyor for additional information.

   Informal conflict prevention may be by telephone, in writing, or in a face-to-face meeting with the regional manager.

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Use of informal conflict prevention does not delay formal imposition of remedies. It also cannot be used to challenge any other aspect of the survey process other than to dispute deficiencies. Aspects of the survey process which cannot be disputed include classification of deficiencies, i.e., scope and harm assessment (SNFs & NFs); failure of survey team in citing deficiencies among facilities; or the inadequacy or inaccuracy of the informal conflict prevention process.

When a provider is unsuccessful during the process at demonstrating that a deficiency should not have been cited, they will be notified in writing by the regional manager that they were unsuccessful.

When a provider is successful, the deficiency will be marked "deleted," signed, and dated by the regional manager and any enforcement action imposed solely because of the deficiency citation will be rescinded. If a "clean" (new) 2567 is requested, a new "clean" plan of correction must be submitted.

9. Regulation interpretations will be developed as appropriate in response to issues raised by administrators and survey staff.

Official regulation interpretations will be signed off by the director of the Adult Care Home Program, MH/MR director, or Hospital Program director and director of the Bureau of Adult and Child Care.

V. Policy - Alternative Sanctions

The state is permitted to continue alternative sanctions in addition to those noted in the Act through the application of KSA 39-945, 946, 947, 948, 949, 951, 952, 953a, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, and 965 to all nursing facilities participating in the medicaid program.

VI. Policy - Provisional Licensure

The state is permitted to continue issuing Provisional Licenses through the application of KSA 39-929 which states, "A provisional license may be issued to any adult care home, the facilities of which are temporarily unable to conform to all the standards, requirements, rules and regulations established under the provisions of this act: Provided, however, that the issuance of such provisional license shall be approved by the state fire marshal. A provisional license may be issued to provide time to make necessary corrections for not more than six (6) months. One additional successive six-month provisional license may be granted at the discretion of the licensing agency. A change of ownership during the provisional licensing period will not extend the time for requirements to be met that were the basis for the provisional license nor entitle the new owner to an additional provisional license.

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Discussion

The Kansas Department of Health and Environment believes that the primary purpose of the survey process is to assure that resident/patients/clients are receiving the care and services required to assist them to function at the highest practicable level. It is the intent of this Department to conduct surveys in a fair and factual manner. There will be instances in this process when disagreements will occur between the surveyor(s) and facility staff. The above procedure will be followed during the survey process to ensure that potential areas of conflict are minimized and disagreements are resolved in a non-adversarial manner.